



NORFOLK

Department of Human Resources

Disability Management Non-Occupational Accommodation Request Form

To: Director, Department of _____
From: _____ Employee
CC: Director, Department of Human Resources
Subject: Accommodation Request of _____

As of _____ (date), I am advising that I am not able to perform the following essential functions of my job without an accommodation:

The reason for my inability is the following condition:

I hereby request the following accommodation to enable me to perform the essential functions of my job:

The requested accommodation(s) would be for the following period of time:

In order for the City to appropriately evaluate the accommodation, which I have requested in regard to my medical condition, I understand and agree that the City may obtain and review information from all health care providers and institutions, which have provided services to me. The following are all the physicians, health care providers and health care institutions, which have provided health care services to me over the past five (5) years:

Name: _____
Address: _____
Phone Number: _____

Name: _____
Address: _____
Phone Number: _____

Name: _____
Address: _____
Phone Number: _____

I understand that the City is relying upon the accuracy and completeness of the information provided by me. I realize that if this form is not returned within 30 days, the City has no obligation to me under the American's with Disabilities Act.

Print Name of Employee

Date

Employee Signature

**AUTHORIZATION FOR
RELEASE AND REVIEW OF
MEDICAL INFORMATION RECORDS AND REPORTS**

I, _____ (Employee), hereby authorize any physician, health care provider or health care institution which has examined or treated me, or which has provided services to me, to furnish to the City of Norfolk, the Department of Human Resources, and/ or its or their employees, agents and representatives, any and all information, records and reports which pertain to any examination and/ or treatment or evaluation of any medical condition and/or treatment rendered to me therefore, and further authorize the City to copy any and all records regarding any such examination or treatment. In addition, I give permission for any physician, health care provider or representative of a health care institution to discuss any and all information records or reports pertaining to the above with the City of Norfolk, Department of Human Resources, Department of Public Health and/ or their employees, agents and representatives.

Print Name

Employee's Signature

Date

Witness

Revised 4/15